

6740

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 5 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithers 85X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Unioq Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Vivian Middle Viola Last Arthur				4. DATE OF DEATH Month 6 Day 30 Year 1958			
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-5-1895		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY House Keeping		11. BIRTHPLACE (State or foreign country) Jackson, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Meck Staten				14. MOTHER'S MAIDEN NAME Minnie Shepard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Arthur Hutchinson, Chesapeake City, Md. Bx. 165			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		6-30-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-30-58		22c. NAME OF CEMETERY OR CREMATORY Hughes Creek Cemetery		22d. LOCATION (City, town, or county) (State) Houston, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home				24a. REC'D BY REGISTRAR MAJ. JUL 7 '58		24b. REGISTRAR'S SIGNATURE W. Leach	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NO. 12345
BALTIMORE

DECEASED

W. W.

Baltimore

1892

John H. H.

John H. H.

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John H. H.

6741

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>113 Landing Lane</u>		d. STREET ADDRESS <u>113 LANDING LANE</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>ELLIS</u> Last <u>BEDWELL</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 19, 1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>IN Elkton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wm. H. Bedwell</u>		14. MOTHER'S MAIDEN NAME <u>MARY SCHAFFER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-03-4192</u>	
17. INFORMANT Address <u>HOSP. CHART Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Prostate</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAY 9</u> , 19 <u>58</u> , to <u>MAY 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MAY 30</u> , 19 <u>58</u> , and that death occurred at <u>9:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. A. Councilll, Jr.</u> M.D.		DATE SIGNED <u>6/13/58</u>	
PHYSICIAN'S NAME (Type) <u>Wilford A. Councilll, Jr.</u>		<u>BALTIMORE 2 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/14/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home</u> ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 16 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. A. Councilll</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>Charles E. Jones</i>		2. SEX <i>Male</i>		3. AGE <i>35</i>	
4. DATE OF DEATH <i>June 10, 1955</i>		5. TIME OF DEATH <i>11:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. DATE OF BIRTH <i>May 15, 1920</i>		11. TIME OF BIRTH <i>10:30 AM</i>		12. PLACE OF BIRTH <i>Baltimore, Md.</i>	
13. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. NAME OF HOSPITAL <i>None</i>		15. NAME OF NURSE <i>None</i>	
16. NAME OF FUNERAL HOME <i>None</i>		17. NAME OF BURIAL PLACE <i>None</i>		18. NAME OF CEMETERY <i>None</i>	
19. NAME OF INTERVIEWER <i>None</i>		20. NAME OF WITNESS <i>None</i>		21. NAME OF SIGNER <i>None</i>	
22. NAME OF REGISTRAR <i>None</i>		23. NAME OF CLERK <i>None</i>		24. NAME OF OFFICE <i>None</i>	
25. NAME OF COUNTY <i>Baltimore</i>		26. NAME OF DISTRICT <i>None</i>		27. NAME OF WARD <i>None</i>	
28. NAME OF BLOCK <i>None</i>		29. NAME OF LOT <i>None</i>		30. NAME OF GRAVE <i>None</i>	
31. NAME OF MONUMENT <i>None</i>		32. NAME OF PLANT <i>None</i>		33. NAME OF FENCE <i>None</i>	
34. NAME OF GATE <i>None</i>		35. NAME OF PATH <i>None</i>		36. NAME OF BRIDGE <i>None</i>	
37. NAME OF TOWER <i>None</i>		38. NAME OF CHURCH <i>None</i>		39. NAME OF SCHOOL <i>None</i>	
40. NAME OF PARK <i>None</i>		41. NAME OF GARDEN <i>None</i>		42. NAME OF LAWN <i>None</i>	
43. NAME OF DRIVE <i>None</i>		44. NAME OF STREET <i>None</i>		45. NAME OF AVENUE <i>None</i>	
46. NAME OF BOULEVARD <i>None</i>		47. NAME OF HIGHWAY <i>None</i>		48. NAME OF RAILROAD <i>None</i>	
49. NAME OF CANAL <i>None</i>		50. NAME OF RIVER <i>None</i>		51. NAME OF LAKE <i>None</i>	
52. NAME OF POND <i>None</i>		53. NAME OF STREAM <i>None</i>		54. NAME OF CREEK <i>None</i>	
55. NAME OF BROOK <i>None</i>		56. NAME OF FALLS <i>None</i>		57. NAME OF DAM <i>None</i>	
58. NAME OF WEIR <i>None</i>		59. NAME OF LOCK <i>None</i>		60. NAME OF TUNNEL <i>None</i>	
61. NAME OF BRIDGE <i>None</i>		62. NAME OF TOWER <i>None</i>		63. NAME OF CHURCH <i>None</i>	
64. NAME OF SCHOOL <i>None</i>		65. NAME OF PARK <i>None</i>		66. NAME OF GARDEN <i>None</i>	
67. NAME OF LAWN <i>None</i>		68. NAME OF DRIVE <i>None</i>		69. NAME OF STREET <i>None</i>	
70. NAME OF AVENUE <i>None</i>		71. NAME OF BOULEVARD <i>None</i>		72. NAME OF HIGHWAY <i>None</i>	
73. NAME OF RAILROAD <i>None</i>		74. NAME OF CANAL <i>None</i>		75. NAME OF RIVER <i>None</i>	
76. NAME OF LAKE <i>None</i>		77. NAME OF POND <i>None</i>		78. NAME OF STREAM <i>None</i>	
79. NAME OF CREEK <i>None</i>		80. NAME OF BROOK <i>None</i>		81. NAME OF FALLS <i>None</i>	
82. NAME OF DAM <i>None</i>		83. NAME OF WEIR <i>None</i>		84. NAME OF LOCK <i>None</i>	
85. NAME OF TUNNEL <i>None</i>		86. NAME OF BRIDGE <i>None</i>		87. NAME OF TOWER <i>None</i>	
88. NAME OF CHURCH <i>None</i>		89. NAME OF SCHOOL <i>None</i>		90. NAME OF PARK <i>None</i>	
91. NAME OF GARDEN <i>None</i>		92. NAME OF LAWN <i>None</i>		93. NAME OF DRIVE <i>None</i>	
94. NAME OF STREET <i>None</i>		95. NAME OF AVENUE <i>None</i>		96. NAME OF BOULEVARD <i>None</i>	
97. NAME OF HIGHWAY <i>None</i>		98. NAME OF RAILROAD <i>None</i>		99. NAME OF CANAL <i>None</i>	
100. NAME OF RIVER <i>None</i>		101. NAME OF LAKE <i>None</i>		102. NAME OF POND <i>None</i>	
103. NAME OF STREAM <i>None</i>		104. NAME OF CREEK <i>None</i>		105. NAME OF BROOK <i>None</i>	
106. NAME OF FALLS <i>None</i>		107. NAME OF DAM <i>None</i>		108. NAME OF WEIR <i>None</i>	
109. NAME OF LOCK <i>None</i>		110. NAME OF TUNNEL <i>None</i>		111. NAME OF BRIDGE <i>None</i>	
112. NAME OF TOWER <i>None</i>		113. NAME OF CHURCH <i>None</i>		114. NAME OF SCHOOL <i>None</i>	
115. NAME OF PARK <i>None</i>		116. NAME OF GARDEN <i>None</i>		117. NAME OF LAWN <i>None</i>	
118. NAME OF DRIVE <i>None</i>		119. NAME OF STREET <i>None</i>		120. NAME OF AVENUE <i>None</i>	
121. NAME OF BOULEVARD <i>None</i>		122. NAME OF HIGHWAY <i>None</i>		123. NAME OF RAILROAD <i>None</i>	
124. NAME OF CANAL <i>None</i>		125. NAME OF RIVER <i>None</i>		126. NAME OF LAKE <i>None</i>	
127. NAME OF POND <i>None</i>		128. NAME OF STREAM <i>None</i>		129. NAME OF CREEK <i>None</i>	
130. NAME OF BROOK <i>None</i>		131. NAME OF FALLS <i>None</i>		132. NAME OF DAM <i>None</i>	
133. NAME OF WEIR <i>None</i>		134. NAME OF LOCK <i>None</i>		135. NAME OF TUNNEL <i>None</i>	
136. NAME OF BRIDGE <i>None</i>		137. NAME OF TOWER <i>None</i>		138. NAME OF CHURCH <i>None</i>	
139. NAME OF SCHOOL <i>None</i>		140. NAME OF PARK <i>None</i>		141. NAME OF GARDEN <i>None</i>	
142. NAME OF LAWN <i>None</i>		143. NAME OF DRIVE <i>None</i>		144. NAME OF STREET <i>None</i>	
145. NAME OF AVENUE <i>None</i>		146. NAME OF BOULEVARD <i>None</i>		147. NAME OF HIGHWAY <i>None</i>	
148. NAME OF RAILROAD <i>None</i>		149. NAME OF CANAL <i>None</i>		150. NAME OF RIVER <i>None</i>	
151. NAME OF LAKE <i>None</i>		152. NAME OF POND <i>None</i>		153. NAME OF STREAM <i>None</i>	
154. NAME OF CREEK <i>None</i>		155. NAME OF BROOK <i>None</i>		156. NAME OF FALLS <i>None</i>	
157. NAME OF DAM <i>None</i>		158. NAME OF WEIR <i>None</i>		159. NAME OF LOCK <i>None</i>	
160. NAME OF TUNNEL <i>None</i>		161. NAME OF BRIDGE <i>None</i>		162. NAME OF TOWER <i>None</i>	
163. NAME OF CHURCH <i>None</i>		164. NAME OF SCHOOL <i>None</i>		165. NAME OF PARK <i>None</i>	
166. NAME OF GARDEN <i>None</i>		167. NAME OF LAWN <i>None</i>		168. NAME OF DRIVE <i>None</i>	
169. NAME OF STREET <i>None</i>		170. NAME OF AVENUE <i>None</i>		171. NAME OF BOULEVARD <i>None</i>	
172. NAME OF HIGHWAY <i>None</i>		173. NAME OF RAILROAD <i>None</i>		174. NAME OF CANAL <i>None</i>	
175. NAME OF RIVER <i>None</i>		176. NAME OF LAKE <i>None</i>		177. NAME OF POND <i>None</i>	
178. NAME OF STREAM <i>None</i>		179. NAME OF CREEK <i>None</i>		180. NAME OF BROOK <i>None</i>	
181. NAME OF FALLS <i>None</i>		182. NAME OF DAM <i>None</i>		183. NAME OF WEIR <i>None</i>	
184. NAME OF LOCK <i>None</i>		185. NAME OF TUNNEL <i>None</i>		186. NAME OF BRIDGE <i>None</i>	
187. NAME OF TOWER <i>None</i>		188. NAME OF CHURCH <i>None</i>		189. NAME OF SCHOOL <i>None</i>	
190. NAME OF PARK <i>None</i>		191. NAME OF GARDEN <i>None</i>		192. NAME OF LAWN <i>None</i>	
193. NAME OF DRIVE <i>None</i>		194. NAME OF STREET <i>None</i>		195. NAME OF AVENUE <i>None</i>	
196. NAME OF BOULEVARD <i>None</i>		197. NAME OF HIGHWAY <i>None</i>		198. NAME OF RAILROAD <i>None</i>	
199. NAME OF CANAL <i>None</i>		200. NAME OF RIVER <i>None</i>		201. NAME OF LAKE <i>None</i>	
202. NAME OF POND <i>None</i>		203. NAME OF STREAM <i>None</i>		204. NAME OF CREEK <i>None</i>	
205. NAME OF BROOK <i>None</i>		206. NAME OF FALLS <i>None</i>		207. NAME OF DAM <i>None</i>	
208. NAME OF WEIR <i>None</i>		209. NAME OF LOCK <i>None</i>		210. NAME OF TUNNEL <i>None</i>	
211. NAME OF BRIDGE <i>None</i>		212. NAME OF TOWER <i>None</i>		213. NAME OF CHURCH <i>None</i>	
214. NAME OF SCHOOL <i>None</i>		215. NAME OF PARK <i>None</i>		216. NAME OF GARDEN <i>None</i>	
217. NAME OF LAWN <i>None</i>		218. NAME OF DRIVE <i>None</i>		219. NAME OF STREET <i>None</i>	
220. NAME OF AVENUE <i>None</i>		221. NAME OF BOULEVARD <i>None</i>		222. NAME OF HIGHWAY <i>None</i>	
223. NAME OF RAILROAD <i>None</i>		224. NAME OF CANAL <i>None</i>		225. NAME OF RIVER <i>None</i>	
226. NAME OF LAKE <i>None</i>		227. NAME OF POND <i>None</i>		228. NAME OF STREAM <i>None</i>	
229. NAME OF CREEK <i>None</i>		230. NAME OF BROOK <i>None</i>		231. NAME OF FALLS <i>None</i>	
232. NAME OF DAM <i>None</i>		233. NAME OF WEIR <i>None</i>		234. NAME OF LOCK <i>None</i>	
235. NAME OF TUNNEL <i>None</i>		236. NAME OF BRIDGE <i>None</i>		237. NAME OF TOWER <i>None</i>	
238. NAME OF CHURCH <i>None</i>		239. NAME OF SCHOOL <i>None</i>		240. NAME OF PARK <i>None</i>	
241. NAME OF GARDEN <i>None</i>		242. NAME OF LAWN <i>None</i>		243. NAME OF DRIVE <i>None</i>	
244. NAME OF STREET <i>None</i>		245. NAME OF AVENUE <i>None</i>		246. NAME OF BOULEVARD <i>None</i>	
247. NAME OF HIGHWAY <i>None</i>		248. NAME OF RAILROAD <i>None</i>		249. NAME OF CANAL <i>None</i>	
250. NAME OF RIVER <i>None</i>		251. NAME OF LAKE <i>None</i>		252. NAME OF POND <i>None</i>	
253. NAME OF STREAM <i>None</i>		254. NAME OF CREEK <i>None</i>		255. NAME OF BROOK <i>None</i>	
256. NAME OF FALLS <i>None</i>		257. NAME OF DAM <i>None</i>		258. NAME OF WEIR <i>None</i>	
259. NAME OF LOCK <i>None</i>		260. NAME OF TUNNEL <i>None</i>		261. NAME OF BRIDGE <i>None</i>	
262. NAME OF TOWER <i>None</i>		263. NAME OF CHURCH <i>None</i>		264. NAME OF SCHOOL <i>None</i>	
265. NAME OF PARK <i>None</i>		266. NAME OF GARDEN <i>None</i>		267. NAME OF LAWN <i>None</i>	
268. NAME OF DRIVE <i>None</i>		269. NAME OF STREET <i>None</i>		270. NAME OF AVENUE <i>None</i>	
271. NAME OF BOULEVARD <i>None</i>		272. NAME OF HIGHWAY <i>None</i>		273. NAME OF RAILROAD <i>None</i>	
274. NAME OF CANAL <i>None</i>		275. NAME OF RIVER <i>None</i>		276. NAME OF LAKE <i>None</i>	
277. NAME OF POND <i>None</i>		278. NAME OF STREAM <i>None</i>		279. NAME OF CREEK <i>None</i>	
280. NAME OF BROOK <i>None</i>		281. NAME OF FALLS <i>None</i>		282. NAME OF DAM <i>None</i>	
283. NAME OF WEIR <i>None</i>		284. NAME OF LOCK <i>None</i>		285. NAME OF TUNNEL <i>None</i>	
286. NAME OF BRIDGE <i>None</i>		287. NAME OF TOWER <i>None</i>		288. NAME OF CHURCH <i>None</i>	
289. NAME OF SCHOOL <i>None</i>		290. NAME OF PARK <i>None</i>		291. NAME OF GARDEN <i>None</i>	
292. NAME OF LAWN <i>None</i>		293. NAME OF DRIVE <i>None</i>		294. NAME OF STREET <i>None</i>	
295. NAME OF AVENUE <i>None</i>		296. NAME OF BOULEVARD <i>None</i>		297. NAME OF HIGHWAY <i>None</i>	
298. NAME OF RAILROAD <i>None</i>		299. NAME OF CANAL <i>None</i>		300. NAME OF RIVER <i>None</i>	
301. NAME OF LAKE <i>None</i>		302. NAME OF POND <i>None</i>		303. NAME OF STREAM <i>None</i>	
304. NAME OF CREEK <i>None</i>		305. NAME OF BROOK <i>None</i>		306. NAME OF FALLS <i>None</i>	
307. NAME OF DAM <i>None</i>		308. NAME OF WEIR <i>None</i>		309. NAME OF LOCK <i>None</i>	
310. NAME OF TUNNEL <i>None</i>		311. NAME OF BRIDGE <i>None</i>		312. NAME OF TOWER <i>None</i>	
313. NAME OF CHURCH <i>None</i>		314. NAME OF SCHOOL <i>None</i>		315. NAME OF PARK <i>None</i>	
316. NAME OF GARDEN <i>None</i>		317. NAME OF LAWN <i>None</i>		318. NAME OF DRIVE <i>None</i>	
319. NAME OF STREET <i>None</i>		320. NAME OF AVENUE <i>None</i>		321. NAME OF BOULEVARD <i>None</i>	
322. NAME OF HIGHWAY <i>None</i>		323. NAME OF RAILROAD <i>None</i>		324. NAME OF CANAL <i>None</i>	
325. NAME OF RIVER <i>None</i>		326. NAME OF LAKE <i>None</i>		327. NAME OF POND <i>None</i>	
328. NAME OF STREAM <i>None</i>		329. NAME OF CREEK <i>None</i>		330. NAME OF BROOK <i>None</i>	
331. NAME OF FALLS <i>None</i>		332. NAME OF DAM <i>None</i>		333. NAME OF WEIR <i>None</i>	
334. NAME OF LOCK <i>None</i>		335. NAME OF TUNNEL <i>None</i>		336. NAME OF BRIDGE <i>None</i>	
337. NAME OF TOWER <i>None</i>		338. NAME OF CHURCH <i>None</i>		339. NAME OF SCHOOL <i>None</i>	
340. NAME OF PARK <i>None</i>		341. NAME OF GARDEN <i>None</i>		342. NAME OF LAWN <i>None</i>	
343. NAME OF DRIVE <i>None</i>		344. NAME OF STREET <i>None</i>		345. NAME OF AVENUE <i>None</i>	
346. NAME OF BOULEVARD <i>None</i>		347. NAME OF HIGHWAY <i>None</i>		348. NAME OF RAILROAD <i>None</i>	
349. NAME OF CANAL <i>None</i>		350. NAME OF RIVER <i>None</i>		351. NAME OF LAKE <i>None</i>	
352. NAME OF POND <i>None</i>		353. NAME OF STREAM <i>None</i>		354. NAME OF CREEK <i>None</i>	
355. NAME OF BROOK <i>None</i>		356. NAME OF FALLS <i>None</i>		357. NAME OF DAM <i>None</i>	
358. NAME OF WEIR <i>None</i>		359. NAME OF LOCK <i>None</i>		360. NAME OF TUNNEL <i>None</i>	
361. NAME OF BRIDGE <i>None</i>		362. NAME OF TOWER <i>None</i>		363. NAME OF CHURCH <i>None</i>	
364. NAME OF SCHOOL <i>None</i>		365. NAME OF PARK <i>None</i>		366. NAME OF GARDEN <i>None</i>	
367. NAME OF LAWN <i>None</i>		368. NAME OF DRIVE <i>None</i>		369. NAME OF STREET <i>None</i>	
370. NAME OF AVENUE <i>None</i>		371. NAME OF BOULEVARD <i>None</i>		372. NAME OF HIGHWAY <i>None</i>	
373. NAME OF RAILROAD <i>None</i>		374. NAME OF CANAL <i>None</i>		375. NAME OF RIVER <i>None</i>	
376. NAME OF LAKE <i>None</i>		377. NAME OF POND <i>None</i>		378. NAME OF STREAM <i>None</i>	
379. NAME OF CREEK <i>None</i>		380. NAME OF BROOK <i>None</i>		381. NAME OF FALLS <i>None</i>	
382. NAME OF DAM <i>None</i>		383. NAME OF WEIR <i>None</i>		384. NAME OF LOCK <i>None</i>	
385. NAME OF TUNNEL <i>None</i>		386. NAME OF BRIDGE <i>None</i>		387. NAME OF TOWER <i>None</i>	
388. NAME OF CHURCH <i>None</i>		389. NAME OF SCHOOL <i>None</i>		390. NAME OF PARK <i>None</i>	
391. NAME OF GARDEN <i>None</i>		392. NAME OF LAWN <i>None</i>		393. NAME OF DRIVE <i>None</i>	
394. NAME OF STREET <i>None</i>		395. NAME OF AVENUE <i>None</i>		396. NAME OF BOULEVARD <i>None</i>	
397. NAME OF HIGHWAY <i>None</i>		398. NAME OF RAILROAD <i>None</i>		399. NAME OF CANAL <i>None</i>	
400. NAME OF RIVER <i>None</i>		401. NAME OF LAKE <i>None</i>		402. NAME OF POND <i>None</i>	
403. NAME OF STREAM <i>None</i>		404. NAME OF CREEK <i>None</i>		405. NAME OF BROOK <i>None</i>	
406. NAME OF FALLS <i>None</i>		407. NAME OF DAM <i>None</i>		408. NAME OF WEIR <i>None</i>	
409. NAME OF LOCK <i>None</i>		410. NAME OF TUNNEL <i>None</i>		411. NAME OF BRIDGE <i>None</i>	
412. NAME OF TOWER <i>None</i>		413. NAME OF CHURCH <i>None</i>		414. NAME OF SCHOOL <i>None</i>	
415. NAME OF PARK <i>None</i>		416. NAME OF GARDEN <i>None</i>		417. NAME OF LAWN <i>None</i>	
418. NAME OF DRIVE <i>None</i>		419. NAME OF STREET <i>None</i>		420. NAME OF AVENUE <i>None</i>	
421. NAME OF BOULEVARD <i>None</i>		422. NAME OF HIGHWAY <i>None</i>		423. NAME OF RAILROAD <i>None</i>	
424. NAME OF CANAL <i>None</i>		425. NAME OF RIVER <i>None</i>		426. NAME OF LAKE <i>None</i>	
427. NAME OF POND <i>None</i>		428. NAME OF STREAM <i>None</i>		429. NAME OF CREEK <i>None</i>	
430. NAME OF BROOK <i>None</i>		431. NAME OF FALLS <i>None</i>		432. NAME OF DAM <i>None</i>	
433. NAME OF WEIR <i>None</i>		434. NAME OF LOCK <i>None</i>		435. NAME OF TUNNEL <i>None</i>	
436. NAME OF BRIDGE <i>None</i>		437. NAME OF TOWER <i>None</i>		438. NAME OF CHURCH <i>None</i>	
439. NAME OF SCHOOL <i>None</i>		440. NAME OF PARK <i>None</i>		441. NAME OF GARDEN <i>None</i>	
442. NAME OF LAWN <i>None</i>		443. NAME OF DRIVE <i>None</i>		444. NAME OF STREET <i>None</i>	
445. NAME OF AVENUE <i>None</i>		446. NAME OF BOULEVARD <i>None</i>		447. NAME OF HIGHWAY <i>None</i>	
448. NAME OF RAILROAD <i>None</i>		449. NAME OF CANAL <i>None</i>		450. NAME OF RIVER <i>None</i>	
451. NAME OF LAKE <i>None</i>		452. NAME OF POND <i>None</i>		453. NAME OF STREAM <i>None</i>	
454. NAME OF CREEK <i>None</i>		455. NAME OF BROOK <i>None</i>		456. NAME OF FALLS <i>None</i>	
457. NAME OF DAM <i>None</i>		458. NAME OF WEIR <i>None</i>		459. NAME OF LOCK <i>None</i>	
460. NAME OF TUNNEL <i>None</i>		461. NAME OF BRIDGE <i>None</i>		462. NAME OF TOWER <i>None</i>	
463. NAME OF CHURCH <i>None</i>		464. NAME OF SCHOOL <i>None</i>		465. NAME OF PARK <i>None</i>	
466. NAME OF GARDEN <i>None</i>		467. NAME OF LAWN <i>None</i>		468. NAME OF DRIVE <i>None</i>	
469. NAME OF STREET <i>None</i>		470. NAME OF AVENUE <i>None</i>		471. NAME OF BOULEVARD <i>None</i>	
472. NAME OF HIGHWAY <i>None</i>		473. NAME OF RAILROAD <i>None</i>		474. NAME OF CANAL <i>None</i>	
475. NAME OF RIVER <i>None</i>		476. NAME OF LAKE <i>None</i>		477. NAME OF POND <i>None</i>	
478. NAME OF STREAM <i>None</i>		479. NAME OF CREEK <i>None</i>		480. NAME OF BROOK <i>None</i>	
481. NAME OF FALLS <i>None</i>		482. NAME OF DAM <i>None</i>		483. NAME OF WEIR <i>None</i>	
484. NAME OF LOCK <i>None</i>		485. NAME OF TUNNEL <i>None</i>		486. NAME OF BRIDGE <i>None</i>	
487. NAME OF TOWER <i>None</i>		488. NAME OF CHURCH <i>None</i>		489. NAME OF SCHOOL <i>None</i>	
490. NAME OF PARK <i>None</i>		491. NAME OF GARDEN <i>None</i>		492. NAME OF LAWN <i>None</i>	
493. NAME OF DRIVE <i>None</i>		494. NAME OF STREET <i>None</i>		495. NAME OF AVENUE <i>None</i>	
496. NAME OF BOULEVARD <i>None</i>		497. NAME OF HIGHWAY <i>None</i>		498. NAME OF RAILROAD <i>None</i>	
499. NAME OF CANAL <i>None</i>		500. NAME OF RIVER <i>None</i>		501. NAME OF LAKE <i>None</i>	
502. NAME OF POND <i>None</i>		503. NAME OF STREAM <i>None</i>		504. NAME OF CREEK <i>None</i>	
505. NAME OF BROOK <i>None</i>		506. NAME OF FALLS <i>None</</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6742

CERTIFICATE OF DEATH

06734

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Thomas Beers				4. DATE OF DEATH June 19 19 58			
5. SEX M	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1888	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Paper Hanging		11. BIRTHPLACE (State or foreign country) Cecil County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard Beers				14. MOTHER'S MAIDEN NAME Sarah Curry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT Address Mrs. Joseph B. Bryson, R.D.#2 Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Duodenal ulcer with hemorrhage							INTERVAL BETWEEN ONSET AND DEATH unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 12, 19 57, to June 19, 19 58, that I last saw the deceased alive on June 18, 19 58, and that death occurred at 1:30p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED S. RALPH ANDREWS, JR., M.D. 235 E. Main Street June 20, 1958 PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D. Elkton, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 22, 1958	22c. NAME OF CEMETERY OR CREMATORY Head of Christiansa		22d. LOCATION (City, town, or county) Newark R. D. Delaware			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS DIPPIN FUNERAL HOME Donald M. Die ELKTON, MD				24a. REC'D BY REGISTRAR DATE JUN 24 '58		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. HENRY		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1910		5. PLACE OF BIRTH BOSTON, MASS.	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1935		9. PLACE OF MARRIAGE BOSTON, MASS.		10. NAME OF SPOUSE MARY J. HENRY	
11. DATE OF DEATH 1955		12. TIME OF DEATH 10:30 AM		13. PLACE OF DEATH Home		14. CAUSE OF DEATH Heart Disease		15. MANNER OF DEATH Natural	
16. SIGNATURE OF PHYSICIAN J. J. HENRY		17. SIGNATURE OF REGISTRAR J. J. HENRY		18. SIGNATURE OF WITNESS J. J. HENRY		19. SIGNATURE OF DECEASED J. J. HENRY		20. SIGNATURE OF SPOUSE MARY J. HENRY	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6743

CERTIFICATE OF DEATH

Reg. Dist. No.

06735

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH EAST</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>		e. STREET ADDRESS <u>RD #2</u>	
3. NAME OF DECEASED (Type or print) First <u>NORRIS</u> Middle <u>D.</u> Last <u>BOYD</u>		4. DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-1912</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GEN. MANAGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WILEY MFG. CO</u>	
11. BIRTHPLACE (State or foreign country) <u>OXFORD, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELIAS BOYD</u>		14. MOTHER'S MAIDEN NAME <u>LAURA TURNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>166-01-3104</u>	
17. INFORMANT <u>ELVA BOYD</u>		Address <u>NORTH EAST RD #2 N.E. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C.V.A (CEREBRAL HEMORRHAGE)</u> DUE TO (c) <u>HYPERTENSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>7 HOURS</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X DIABETES</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>WAS NOT</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-3-1958</u> , to <u>6-4-1958</u> , that I last saw the deceased alive on <u>6-4-1958</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>WALLACE AVE NORTH EAST MARYLAND</u> DATE SIGNED <u>WALLACE AVE</u>			
ACTUAL SIGNATURE <u>Luis M. Cuza</u> M.D.		DATE SIGNED <u>WALLACE AVE</u>	
PHYSICIAN'S NAME (Type) <u>LUIS M. CUZA</u>		DATE SIGNED <u>NORTH EAST MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/6/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oxford Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Oxford Penn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Demone E. McMillen</u>		ADDRESS <u>Rising Sun Md.</u>	
24a. REC'D BY REGISTRAR <u>JUN 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6750 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06736

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN lb 13 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) V.F.W. Home				d. STREET ADDRESS Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James		First F Middle Bradley		4. DATE OF DEATH 6 7 1958		Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-17-1916		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Bradley			14. MOTHER'S MAIDEN NAME Lillian Kerr				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes W.W.2		16. SOCIAL SECURITY NO. 216-09-2229		17. INFORMANT Mrs. Margaret A. Reir, Bx. 241 Rmt 16			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6-11-58		22c. NAME OF CEMETERY OR CREMATORY Balto. Nat Cemetery	
22d. LOCATION (City, town, or county) Baltimore, Md.		22e. (State) Md.		22f. (City, town, or county) Baltimore, Md.		22g. (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph A. Hunt				24a. REC'D BY REGISTRAR DATE JUN 10 '58		24b. REGISTRAR'S SIGNATURE W. J. Leach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06737

Reg. Dist. No.

6751

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aiken		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) George Burch Wharf.				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last Abner Leslie Burrows				4. DATE OF DEATH Month Day Year 6 14 1958			
5. SEX M	6. COLOR OR RACE M	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 20 1900		9. AGE (in years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P.R.R. Sta. Agent		10b. KIND OF BUSINESS OR INDUSTRY Agent for P.R.R.		11. BIRTHPLACE (State or foreign country) Kenton, Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abner R. Burrows				14. MOTHER'S MAIDEN NAME Mary Elizabeth Redgrave			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 716-01-7822		17. INFORMANT Mrs. Mary E. Burrows, Aiken, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
EXAMINER'S NAME (Type) R.C. Dodson, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6-15-58			
22a. BURIAL, CREMATION, or other disposition (Type) Burial		22b. DATE THEREOF 6-17-1958		22c. NAME OF CEMETERY OR CREMATORY Hopewell Cem.		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE JUN 18 '58	
						24b. REGISTRAR'S SIGNATURE W. J. Smith	

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Acute Coronary Infarction

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06738

6744

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 30 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
3. NAME OF DECEASED (Type or print) First Middle Last ETHEL MARIE FOREACRE		4. DATE OF DEATH Month 6 Day 14 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3.3.1923
9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Marion, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Matt Cole		14. MOTHER'S MAIDEN NAME Dolly Ethel WEEK Owens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-26-4775	
17. INFORMANT Peter Foreacre		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 104.1 B Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rocky Mountain Spotted Fever DUE TO (c) 322! Malnutrition chronic alcoholism		INTERVAL BETWEEN ONSET AND DEATH 2 days 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 322! Malnutrition chronic alcoholism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6.9, 1958, to 6.14, 1958, that I last saw the deceased alive on 6.14, 1958, and that death occurred at 3:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Peter Stavrakis M.D. 154 W MAIN 6.14.58 PHYSICIAN'S NAME (Type) PETER STAVRAKIS ELKTON, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/1958	
22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pippin Funeral Home Elkton, Md.		24a. REC'D BY REGISTRAR DATE JUN 17 '58	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6752

CERTIFICATE OF DEATH

Reg. Dist. No. 06739

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cecilton		c. LENGTH OF STAY IN 1b 4yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Cecilton	
3. NAME OF DECEASED (Type or print) Vernon First Middle Last Husfelt		4. DATE OF DEATH June Month Day Year 26 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1912
9. AGE (In years last birthday) 45		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Tenant Farmer	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Husfelt		14. MOTHER'S MAIDEN NAME Sarah Boulden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 219-36-0343	
17. INFORMANT Elizabeth Husfelt Rural Middletown Del.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 hours 5 years 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/6, 1952, to 6/26, 1958, that I last saw the deceased alive on 6/26, 1958, and that death occurred at 11:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry L. Hoch		ADDRESS (Street, city or town, state) Middletown, Del.	
PHYSICIAN'S NAME (Type) HARRY L. HOCH		DATE SIGNED 6/27/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 29, 1958	
22c. NAME OF CEMETERY OR CREMATORY Johntown Cem.		22d. LOCATION (City, town, or county) Earleville (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Ellow		ADDRESS Middletown Md.	
24a. REC'D BY REGISTRAR DATE JUL 1 '58		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

COUNTY OF <u>ALLEGANY</u> STATE OF <u>MARYLAND</u>		DEPARTMENT OF HEALTH BALTIMORE	
NAME OF DECEASED <u>JOHN J. HARRIS</u> SEX <u>MALE</u>		DATE OF DEATH <u>1910</u> PLACE OF DEATH <u>HOME</u>	
AGE <u>45</u> YEARS OCCUPATION <u>LABORER</u>		CAUSE OF DEATH <u>HEART DISEASE</u> MEDICAL OPINION <u>HEART DISEASE</u>	
PLACE OF BIRTH <u>IRELAND</u> DATE OF BIRTH <u>1865</u>		PLACE OF DEATH <u>HOME</u> DATE OF DEATH <u>1910</u>	
NAME OF PHYSICIAN <u>DR. J. H. HARRIS</u> SIGNATURE <u>[Signature]</u>		NAME OF WITNESS <u>JOHN J. HARRIS</u> SIGNATURE <u>[Signature]</u>	
NAME OF CORONER <u>JOHN J. HARRIS</u> SIGNATURE <u>[Signature]</u>		NAME OF JURY <u>JOHN J. HARRIS</u> SIGNATURE <u>[Signature]</u>	
NAME OF DECEASED <u>JOHN J. HARRIS</u> SEX <u>MALE</u>		DATE OF DEATH <u>1910</u> PLACE OF DEATH <u>HOME</u>	
AGE <u>45</u> YEARS OCCUPATION <u>LABORER</u>		CAUSE OF DEATH <u>HEART DISEASE</u> MEDICAL OPINION <u>HEART DISEASE</u>	
PLACE OF BIRTH <u>IRELAND</u> DATE OF BIRTH <u>1865</u>		PLACE OF DEATH <u>HOME</u> DATE OF DEATH <u>1910</u>	
NAME OF PHYSICIAN <u>DR. J. H. HARRIS</u> SIGNATURE <u>[Signature]</u>		NAME OF WITNESS <u>JOHN J. HARRIS</u> SIGNATURE <u>[Signature]</u>	
NAME OF CORONER <u>JOHN J. HARRIS</u> SIGNATURE <u>[Signature]</u>		NAME OF JURY <u>JOHN J. HARRIS</u> SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06740

6753

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Port Deposit</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Port Deposit</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>M.</u> Last <u>Kelley</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 20, 1882</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		9c. PLACE OF BIRTH (State or foreign country) <u>Cecil County</u>		9d. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Kelley</u>				14. MOTHER'S MAIDEN NAME <u>Laura Luckens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mahlon Kelley Port Deposit Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 290.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Phenolic Acid</u> DUE TO (c) <u>10 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 10</u> , 19 <u>58</u> , to <u>June 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 4</u> , 19 <u>58</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Port Deposit, Md</u>				DATE SIGNED <u>6-6-58</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery Port Deposit Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed, Rising Sun Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>JUN 10 58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John J. ...</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>...</i></p>		<p>4. DATE OF BIRTH <i>...</i></p>	
<p>5. PLACE OF BIRTH <i>...</i></p>		<p>6. OCCUPATION <i>...</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF DEATH <i>...</i></p>	
<p>9. TIME OF DEATH <i>...</i></p>		<p>10. PLACE OF DEATH <i>...</i></p>	
<p>11. CAUSE OF DEATH <i>...</i></p>		<p>12. MEDICAL HISTORY <i>...</i></p>	
<p>13. SIGNATURE OF PHYSICIAN <i>...</i></p>		<p>14. SIGNATURE OF REGISTRAR <i>...</i></p>	
<p>15. SIGNATURE OF WITNESS <i>...</i></p>		<p>16. SIGNATURE OF DECEASED <i>...</i></p>	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A REGISTRAR OF THE DEPARTMENT OF HEALTH. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON.

6754

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 96

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 7 yrs. 1 mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3601-4 ✓		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			d. STREET ADDRESS 1409 N. Patterson Park Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle S. Last KRIES			4. DATE OF DEATH Month June Day 27 Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-3-92	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Lawrence J. Kries		14. MOTHER'S MAIDEN NAME Anna Hooper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None					INTERVAL BETWEEN ONSET AND DEATH 2 Minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R. L. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/27-58	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/58		22c. NAME OF CEMETERY OR CREMATORY Lorraine	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichner & Sons		ADDRESS Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06742

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. LENGTH OF STAY IN 1b <u>6 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Jackson Lindamood</u>			4. DATE OF DEATH Month Day Year <u>6 22 19 58</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-4-1905</u>		9. AGE (In years last birthday) <u>53</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurses Aid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hosp. Work</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Wesley Jackson</u>			14. MOTHER'S MAIDEN NAME <u>Leera Woodrow</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-18-7554</u>		17. INFORMANT <u>Mrs. Roland Creswell, Port Deposit, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Port Deposit, Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>R.C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-23-58</u>	
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-26-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>W. Nottingham</u>	
22d. LOCATION (City, town, or county) <u>Colora, Cecil Co. Md.</u>		22e. REC'D BY REGISTRAR <u>Lee A. Patterson & Son Perryville, Md</u>		22f. REGISTRAR'S SIGNATURE <u>Lee A. Patterson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06743

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 317 W. Main St.		d. STREET ADDRESS 317 W. Main St.	
3. NAME OF DECEASED (Type or print) First Middle Last Ida R. Hart		4. DATE OF DEATH June 9 1958	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1868
9. AGE (In years last birthday) 90		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY House Wife	
11. BIRTHPLACE (State or foreign country) Colora, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Josiah Woodrow		14. MOTHER'S MAIDEN NAME Jane E. Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Katie Marcus		317 W. Main St. Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Cardiac Failure (b) Generalized Arteriosclerosis. (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 to June 9, 1958, that I last saw the deceased alive on June 9, 1958, and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Milford H. Sprecher M.D.		DATE SIGNED June 11, 1958	
PHYSICIAN'S NAME (Type) Milford H. Sprecher			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE-THEREOF 6-12-1958	22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cherry Hill, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Pippin Funeral Home		24a. REC'D BY REGISTRAR DATE JUN 16 '58	
		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6756

CERTIFICATE OF DEATH

06744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pratt's Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle Mackey Last Mackey		4. DATE OF DEATH Month 6/15/58 Day 19 Year 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1870
9. AGE (In years last birthday) 88 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired/ Carpenter B.&O.R.R.	
11. BIRTHPLACE (State or foreign country) Donegal, Ireland		12. CITIZEN OF WHAT COUNTRY? Nat. 8/4/37-USA	
13. FATHER'S NAME David Mackey		14. MOTHER'S MAIDEN NAME Jane Oliver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mrs. E. Mackey, North East, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Generalized Arteriosclerosis DUE TO (b) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) — DUE TO (d) —			INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 May, 1958, to 15 June, 1958, that I last saw the deceased alive on 10 June, 1958, and that death occurred at 8:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Klaus H. Huebner M.D.		ADDRESS (Street, city or town, state) North East, Md. DATE SIGNED 15 June '58	
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 6/18/58	22c. NAME OF CEMETERY OR CREMATORY Gracelawn Memorial Park, Farnhurst, Delaware	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Shraw		ADDRESS North East Md.	
24a. REC'D BY REGISTRAR DATE JUN 18 '58		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
USE ONLY

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For report
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06746**

6758

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Del. b. COUNTY Newcastle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington 47X-3	
c. LENGTH OF STAY IN 1b 2 mo.		d. STREET ADDRESS 1122 Lancaster Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle A. Last Murphy		4. DATE OF DEATH Month 6 Day 27 Year 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4- 1895
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 6 Days 27 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. R.R. Engineer		10b. KIND OF BUSINESS OR INDUSTRY P.R.R.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Henry Murphy		14. MOTHER'S MAIDEN NAME Bertha McGuirk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes W.W.I		16. SOCIAL SECURITY NO. Ralph H. Murphy, Charlestown, Md.	
17. INFORMANT Ralph H. Murphy, Charlestown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Reed Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-27-58	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 6-30-1958	22c. NAME OF CEMETERY OR CREMATORY Burial, Cathedral, Cem	22d. LOCATION (City, town, or county) (State) Wilmington, Delaware
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son,		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR JUL 1 '58		24b. REGISTRAR'S SIGNATURE Reed Dodson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Residence

City

County

Birthplace

Age

Occupation

1125 Lombard Ave.

27

1900

X

White

Male

Married

Single

Married

Single

Single

Single

Single

Single

Acute Coronary Occlusion

Information

1. Name of patient
2. Date of death
3. Time of death
4. Place of death
5. Cause of death
6. Manner of death
7. Signature of examiner
8. Signature of physician
9. Signature of coroner
10. Signature of registrar

DATE OF DEATH
TIME OF DEATH
PLACE OF DEATH

X

X

X

X

X

X

1900

1900

1900

1900

1900

1900

1900

6759

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -				d. STREET ADDRESS Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Luba Middle H. Last Porcaro				4. DATE OF DEATH Month 6 Day 22 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 5, 1896		9. AGE (In years last birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire works maker		10b. KIND OF BUSINESS OR INDUSTRY Pyrotechnics		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Cameron				14. MOTHER'S MAIDEN NAME Sarah Weaver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-01-5072		17. INFORMANT Address Mrs Albert H. Reed North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 year 8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Allergic Bronchial Asthma						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -			
20c. TIME OF INJURY Month, Day, Year Hour o. m. - p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) -	
21. I certify that I attended the deceased from Feb. , 19 51 , to 22 June , 19 58 , that I last saw the deceased alive on 31 May , 19 58 , and that death occurred at 5 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) North East, Md DATE SIGNED 23 June '58							
ACTUAL SIGNATURE Klaus H. Heubner M.D.				DATE SIGNED 23 June '58			
PHYSICIAN'S NAME (Type) Klaus H. Heubner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-25-1958		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R Grant North East, Maryland				24a. REC'D BY REGISTRAR DATE JUN 26 '58		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G230 7-2-58 et

6746

CERTIFICATE OF DEATH

Reg. Dist. No. 06748

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna b. COUNTY Del.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester 75 x -3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp.				d. STREET ADDRESS 208 W 15th St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle E. Last Reeder				4. DATE OF DEATH Month June Day 24 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Approx. 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Millard Reeder				14. MOTHER'S MAIDEN NAME Annie Reedy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 171-10-6769		17. INFORMANT Hospital Records, Union Hosp. Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 days year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 21 June , 19 58 , to 23 June , 19 58 , that I last saw the deceased alive on 23 June , 19 58 , and that death occurred at 5:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wallace Obershain M.D.				ADDRESS (Street, city or town, state) Pecilton			
PHYSICIAN'S NAME (Type) Wallace Obershain				Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-27-1958		22c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		22d. LOCATION (City, town, or county) (State) West Chester, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR JUN 26 58	
				24b. REGISTRAR'S SIGNATURE W. F. Smith			

DISCUSSION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6760

06749

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East R.D. c. LENGTH OF STAY IN 1b 2month		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East, R.D. d. STREET ADDRESS Spence Trailer Camp e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Sylvester Last Rehrer		4. DATE OF DEATH Month 6 Day 25 Year 1958	
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-17-1909
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 6 Days 25	IF UNDER 24 HRS. Hours 15 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Pennsylvania.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Rehrer		14. MOTHER'S MAIDEN NAME Fannie Weirick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 198-10-7064	
17. INFORMANT Mrs. J.S. Reherer, North East, R.D. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide gas poisoning 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Attached hose to exhaust of car and locked car.	
20c. TIME OF INJURY Month, Day, Year Hour 3:45 p. m. 6 25 58		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods 20f. (City or town) North East Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		DATE SIGNED 6-26-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June, 28, 1958	
22c. NAME OF CEMETERY OR CREMATORY Belair Memorial Garden		22d. LOCATION (City, town, or county) Belair Harford Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. McComas		24a. REC'D BY REGISTRAR Abingdon, Maryland.	
24b. REGISTRAR'S SIGNATURE W. J. Seabach		DATE JUN 30 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

Name of Deceased		John Doe	
Age		45	
Sex		Male	
Race		White	
Date of Death		1-17-1909	
Place of Death		Home, 123 Main St., Baltimore, Md.	
Cause of Death		Diphtheria	
Manner of Death		Natural	
Signature of Medical Examiner		J. H. Smith	
Signature of Coroner		W. B. Jones	
Signature of Registrar		M. A. Brown	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No. **06750**

6747

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 30 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 260 W. Main		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sterling Silver Reynolds				4. DATE OF DEATH Month Day Year 6 5 19 58			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-15-1900		9. AGE (In years last birthday) 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill hand		10b. KIND OF BUSINESS OR INDUSTRY Fiber Mill		11. BIRTHPLACE (State or foreign country) North East, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Richard Reynolds				14. MOTHER'S MAIDEN NAME Anna Lloyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-01-8130		17. INFORMANT Address Mrs. Sterling Reynolds, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 8 1958		22c. NAME OF CEMETERY OR CREMATORY Elkton		22d. LOCATION (City, town, or county) (State) Elkton Cecil Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R Grant				24a. REC'D BY REGISTRAR DATE JUN 9 '58		24b. REGISTRAR'S SIGNATURE Alfred	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

NO. 1000
EXAMINEE

Geoff

Union

Union

Union

Union

Union

218-01-8130

Acute Coronary Thrombosis

Mrs. Stephanie Reynolds, Kinston, N.C.

Anna Lloyd

Korck East, N.C.

U.S.A.

1-15-1900

Reynolds

600 W. Main

Kinston

Reynolds

Geoff

WYOMING STATE DEPARTMENT OF HEALTH - SALT LAKE CITY, UTAH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06751

Reg. Dist. No.

6748

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	c. LENGTH OF STAY IN 1b All life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.2.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS White Hall Road.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Alverta First Amelia Rothwell Last	4. DATE OF DEATH Month 6 Day 6 Year 19 58		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-1903
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY House work	11. BIRTHPLACE (State or foreign country) Elkton, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Crothers		14. MOTHER'S MAIDEN NAME Mary Lynch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. =====	17. INFORMANT Address Arthur M. Rothwell. Elkton, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-6-58	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/9/1958	22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	22d. LOCATION (City, town, or county) (State) Md. Elkton
23. FUNERAL DIRECTOR'S SIGNATURE H. Walter duBois		ADDRESS Elkton Md.	24a. REC'D BY REGISTRAR DATE JUN 10 '58
		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6749

CERTIFICATE OF DEATH

06752

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Sevier</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Sevier</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Elkton</u>		LENGTH OF STAY (in this place) <u>10</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton - MD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lincoln Hospital - Elkton - Md</u>				STREET ADDRESS (If rural give location) <u>Maryland</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Adam</u> (Middle) <u>—</u> (Last) <u>Snyder</u>				(Month) <u>June</u> (Day) <u>16th</u> (Year) <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Apr 27-1878</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months <u>—</u> Days <u>—</u>		Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore - Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>169-10-5176</u>		17. INFORMANT & ADDRESS <u>Reginald C. Brown</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				<u>Hypertension + General Arterio-Sclerosis</u>		<u>30 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 27-1958</u> , to <u>June 16-1958</u> , that I last saw the deceased alive on <u>June 16-1958</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>T. H. McLaughlin</u>				DATE SIGNED <u>6-16-1958</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				DATE THEREOF <u>6/19/58</u>		NAME OF CEMETERY OR CREMATORY <u>BUSH CREEK COM.</u>	
24. REC'D BY REGISTRAR <u>W. H. Leach</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Leach</u>		ADDRESS <u>Elkton, Md</u>	
DATE <u>JUN 20 '58</u>							

CERTIFICATE OF DEATH

Form 100-100

1. DECEASED'S NAME (Last, first, middle)

2. SEX (Male or Female)

3. AGE (Years, months, days)

4. DATE OF BIRTH (Month, day, year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (If any)

7. MARITAL STATUS (Single, Married, Widowed, Divorced)

8. EDUCATION (Grade completed)

9. RELIGION (If any)

10. RACE (White, Negro, Other)

11. COLOR (If other than white)

12. US BIRTH (Yes or No)

13. DATE OF DEATH (Month, day, year)

14. TIME OF DEATH (Hour, minute)

15. PLACE OF DEATH (City, State, Country)

16. CAUSE OF DEATH (Immediate)

17. CAUSE OF DEATH (Underlying)

18. CAUSE OF DEATH (Contributing)

19. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)

20. SIGNATURE OF PHYSICIAN (If any)

21. SIGNATURE OF REGISTRAR (If any)

22. SIGNATURE OF WITNESSES (If any)

23. SIGNATURE OF DECEASED (If any)

24. SIGNATURE OF NEXT OF KIN (If any)

25. SIGNATURE OF OTHER (If any)

26. SIGNATURE OF OTHER (If any)

27. SIGNATURE OF OTHER (If any)

28. SIGNATURE OF OTHER (If any)

29. SIGNATURE OF OTHER (If any)

30. SIGNATURE OF OTHER (If any)

31. SIGNATURE OF OTHER (If any)

32. SIGNATURE OF OTHER (If any)

33. SIGNATURE OF OTHER (If any)

34. SIGNATURE OF OTHER (If any)

35. SIGNATURE OF OTHER (If any)

36. SIGNATURE OF OTHER (If any)

37. SIGNATURE OF OTHER (If any)

38. SIGNATURE OF OTHER (If any)

39. SIGNATURE OF OTHER (If any)

40. SIGNATURE OF OTHER (If any)

41. SIGNATURE OF OTHER (If any)

42. SIGNATURE OF OTHER (If any)

43. SIGNATURE OF OTHER (If any)

44. SIGNATURE OF OTHER (If any)

2. DECEASED'S NAME (Last, first, middle)

3. SEX (Male or Female)

4. AGE (Years, months, days)

5. DATE OF BIRTH (Month, day, year)

6. PLACE OF BIRTH (City, State, Country)

7. OCCUPATION (If any)

8. MARITAL STATUS (Single, Married, Widowed, Divorced)

9. EDUCATION (Grade completed)

10. RELIGION (If any)

11. RACE (White, Negro, Other)

12. COLOR (If other than white)

13. US BIRTH (Yes or No)

14. DATE OF DEATH (Month, day, year)

15. TIME OF DEATH (Hour, minute)

16. PLACE OF DEATH (City, State, Country)

17. CAUSE OF DEATH (Immediate)

18. CAUSE OF DEATH (Underlying)

19. CAUSE OF DEATH (Contributing)

20. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)

21. SIGNATURE OF PHYSICIAN (If any)

22. SIGNATURE OF REGISTRAR (If any)

23. SIGNATURE OF WITNESSES (If any)

24. SIGNATURE OF DECEASED (If any)

25. SIGNATURE OF NEXT OF KIN (If any)

26. SIGNATURE OF OTHER (If any)

27. SIGNATURE OF OTHER (If any)

28. SIGNATURE OF OTHER (If any)

29. SIGNATURE OF OTHER (If any)

30. SIGNATURE OF OTHER (If any)

31. SIGNATURE OF OTHER (If any)

32. SIGNATURE OF OTHER (If any)

33. SIGNATURE OF OTHER (If any)

34. SIGNATURE OF OTHER (If any)

35. SIGNATURE OF OTHER (If any)

36. SIGNATURE OF OTHER (If any)

37. SIGNATURE OF OTHER (If any)

38. SIGNATURE OF OTHER (If any)

39. SIGNATURE OF OTHER (If any)

40. SIGNATURE OF OTHER (If any)

41. SIGNATURE OF OTHER (If any)

42. SIGNATURE OF OTHER (If any)

43. SIGNATURE OF OTHER (If any)

44. SIGNATURE OF OTHER (If any)

45. SIGNATURE OF OTHER (If any)

100-10-2176

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6761

CERTIFICATE OF DEATH

Reg. Dist. No.

06754

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN TB 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS Rural			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> unknown							
3. NAME OF DECEASED (Type or print) First ALPHONSE Middle J. Last WEAVER		4. DATE OF DEATH Month June Day 19 Year 19 58					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-18-16	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months 42 Days 19 Hours 58 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Shop Worker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas J. Weaver - Deceased				14. MOTHER'S MAIDEN NAME Margaret Lingan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 215 03 3248		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease, type undetermined, with 434.3 DUE TO cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH unknown							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15 , 19 58 , to June 19 , 19 58 , that I attended the deceased and that death occurred at 4:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 6-19-58 ACTUAL SIGNATURE S. P. LACERVA M.D. S. P. LACERVA PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-23-58		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Hyde, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter H. Archer WALTER H. ARCHER, Benson, Maryland				24a. REC'D BY REGISTRAR JUN 23 58 DATE		24b. REGISTRAR'S SIGNATURE Ch. Lewis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1866		Maryland		Baltimore		Heart Disease		Jan 15, 1911		10:00 AM		Home		J. A. Smith		W. B. Jones	
Occupation		Married		Single		Widowed		Divorced		Color		Race		Religion		Education		Previous Illness		Mental Condition		Alcohol	
Teacher		Yes		No		No		No		White		Caucasian		Protestant		High School		None		Normal		None	
Date of Death		Time of Death		Place of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Cause of Death	
Jan 15, 1911		10:00 AM		Home		Heart Disease		Jan 15, 1911		10:00 AM		Home		Heart Disease		Jan 15, 1911		10:00 AM		Home		Heart Disease	
Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
J. A. Smith		W. B. Jones		J. A. Smith		W. B. Jones		J. A. Smith		W. B. Jones		J. A. Smith		W. B. Jones		J. A. Smith		W. B. Jones		J. A. Smith		W. B. Jones	

W. B. Jones



1 50 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 50 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6762

CERTIFICATE OF DEATH

Reg. Dist. No.

96756

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 1 mo. 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park 1614-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 8205 Baltimore Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WALTER Middle A. Last WHEATLEY				4. DATE OF DEATH Month June Day 26 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-1-1905	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53		IF UNDER 24 HRS. Days 53 Hours 53 Min. 53			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur				10b. KIND OF BUSINESS OR INDUSTRY Taxicab Company		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Warnick Wheatley				14. MOTHER'S MAIDEN NAME Florence Hedricks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis, original site unknown 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 199.2 DUE TO (c) 199.2							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 199.2							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. VA 19 p. m. VA				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				20g. (County) VA		20h. (State) VA	
21. I certify that I attended the deceased from May 19 , 19 58 , to June 26 , 19 58 , and that death occurred at 8:05 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. M. HARRIS				ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 6-26-58			
PHYSICIAN'S NAME (Type) W. M. HARRIS				Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) 6/28/58		22b. DATE THEREOF 6/28/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) Arlington, Virginia (State) VA	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son ADDRESS Bayre de Grace, Md.				24a. REC'D BY REGISTRAR 6/28/58 24b. REGISTRAR'S SIGNATURE W. M. HARRIS			

